

APPLICATION FOR MEDICAL CLAIMS REVIEW CONSULTANT

INDIANA DEPARTMENT OF INSURANCE

Check if New Application	<input type="checkbox"/>
Check if Renewal	<input type="checkbox"/>

For Dept. use only:
Date Fee processed _____
Date Registration processed _____

INSTRUCTIONS:

If there has been no change in the documentation submitted for your last renewal application, submit this completed application and the renewal fee.

If there has been **ANY** change to the documentation submitted with your last renewal application or new application filed since June 30, submit the revised documentation with this completed application, the completed application checklist and renewal fee.

Please notify the Department of Insurance of any material change of any information set forth in this application within thirty (30) days of the change.

Please submit the documents satisfying the requirement that you will maintain the confidentiality of any medical records that are disclosed to you according to the provisions outlined in 760 IAC 1-49-8.

Please **TYPE** responses to the questions below.

Name of Medical Claims Review Consultant		D/B/A name	
FIN/EIN Number			
Address (if P.O. Box, please include street address)			
City	State		Zip Code – Nine Digits
Telephone Number		Fax Number	
Name of contact person		Telephone number of contact person	
E-mail for contact person		Company Website, if applicable	
<i>A Medical Claims Review Consultant is defined as one (person or entity) that “makes recommendations or provides consultation to”:</i> <i>1. An entity performing MCR reviews or</i> <i>2. An insurance company or</i> <i>3. An HMO or</i> <i>4. A benefit program that pays, reimburses, or indemnifies health care costs to a covered person regarding the appropriateness of health care services or the amount charged for such services provided to the covered person.</i>			
<i>I certify that <input type="checkbox"/> there have been no changes to any application information and documentation submitted during the last year;</i> <i>or</i> <i>I certify that <input type="checkbox"/> there have been changes to the previously submitted application information and documentation and have attached the revised documentation.</i>			
<i>I certify that the above statements are true.</i>			
Signature of applicant	Date	Printed Name of Signature	Title